CHAPTER 6-000 DENTAL SERVICES

6-001 Definitions

Adequate Occlusion for Partial Dentures: First molar to first molar, or a similar combination of anterior and posterior teeth on the upper or lower arch in occlusion.

Handicapping Malocclusion: An improper alignment of the teeth due to one of two conditions:

i. Craniofacial birth defect that is affecting the occlusion.
ii. Mutilated and severe malocclusions.

Medicaid uses the Handicapping Labiolingual Deviation (HLD) Index to determine whether coverage is appropriate based on a handicapping malocclusion. The HLD Orthodontic Diagnostic Score Sheet is included within 471-000-406, with a score of 28 or greater being necessary to qualify for Medicaid coverage of orthodontic treatment.

Occlusal Orthotic Device: Splints that are provided for treatment of temporomandibular joint dysfunction.

Special Needs: For the purposes of this Dental Services, a client with special needs is a client who is unable to care for his/her mouth properly on his/her own because of a disabling condition.

6-002 Provider Requirements:

6-002.01 General Provider Requirements: To participate in the Nebraska Medical Assistance Program (Medicaid), providers of dental services shall comply with all applicable participation requirements codified in 471 NAC Chapters 1, 2 and 3. In the event that participation requirements in 471 NAC Chapters 1, 2 or 3 conflict with requirements outlined in this 471 NAC Chapter 6, the provider participation requirements in 471 NAC Chapter 6 shall govern.

6-002.02 Service Specific Provider Requirements: Providers of dental services must be licensed by the Nebraska Department of Health and Human Services as a dentist or a dental hygienist and must practice within their scope of practice as defined in Neb. Rev. Stat. Sections 38-1101 to 38-1151. If services are provided in another state, the dentist or dental hygienist must be licensed in that state, must practice within his/her scope of practice as defined by the licensing laws for that state, and must be enrolled in Nebraska Medicaid by complying with the Provider Agreement requirements included in 471 NAC 6-002.02A.

6-002.02A Provider Agreement: Providers of dental services shall complete and sign Form MC-19, "Medical Assistance Provider Agreement," (see 471-000-90) and submit the

completed form to the Nebraska Department of Health and Human Services for approval to participate in Medicaid.

6-003 Service Requirements

6-003.01 General Requirements

6-003.01A Medical Necessity: Dental services must be delivered in accordance with generally accepted, evidence-based medical standards. Dental services must be:

i. Reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition that endangers life, causes suffering or pain, or has resulted or will result in a handicap, physical deformity or malfunction;
ii. Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment;
iii. The least costly service meeting the treatment needs. There can be no equally effective, more conservative, and less costly course of treatment available or suitable for the client.
iv. Within the scope of the coverage criteria contained in these regulations;
v. Within accepted dental or medical practice standards; and,
vi. Consistent with a diagnosis of dental disease or condition.

Services may be subject to the specific limitations or prior authorization requirements as listed in 471 NAC 6-003.

6-003.01A1 Documentation of Medical Necessity: Documentation of medical necessity is required on all procedures. The documentation should be in the client's dental chart which must be available to the Department upon request.

6-003.01B Prior Authorization: The provider must receive prior authorization before providing the following services:

i. Crowns. See 471 NAC 6-003.02C2 for specific documentation requirements.
ii. Periodontal Scaling and Root Planing. See 471 NAC 6-003.02E2 for documentation requirements.
iii. Periodontal Maintenance Procedure. See 471 NAC 6-003.02E4 for documentation requirements.
iv. Complete, Immediate and Interim Dentures (Maxillary and Mandibular). See 471 NAC 6-003.02F2, 471 NAC 6-003.02F3 and 471 NAC 6-003.02F10 for documentation requirements.
v. Partial Resin Base (Maxillary and Mandibular). See 471 NAC 6-003.02F4 for documentation requirements.
vi. Flipper Partial Dentures (Maxillary and Mandibular). See 471 NAC 6-003.02F11 for documentation requirements.
vii. Orthodontic Treatment. See 471 NAC 6-003.02H for documentation requirements.

Specific documentation must be submitted along with each prior authorization request. Submitted documentation that is inadequate, or does not otherwise meet the criteria for review, may be disapproved, or returned for additional information or correction.

6-003.01B1 Request for Prior Authorization: To request prior authorization for a proposed dental pre-treatment plan or covered service, the dentist must submit the request using one of the following options:

a. Electronically using the standard Health Care Services Review – Request for Review and Response transaction (ASC X12N 278);
b. Submission of a dental claim form and required documentation:
   i. by mail to:
      Department of Health and Human Services
      Division of Medicaid and Long Term Care
      P. O. Box 95026
      Lincoln, NE 68509-5026;
   ii. by fax to: 402-742-8342; or
   iii. by email to: dhhs.medicaiddental@nebraska.gov.

Copies of documentation should be provided to the Department and original documentation should be retained by the Provider. Medicaid cannot guarantee the return of submitted original documentation.

6-003.01B2 Medicaid Eligibility: Providers shall re-check Medicaid client eligibility before starting a service, even with an approved prior authorization. Since Medicaid eligibility may vary from month to month, Medicaid cannot guarantee that the eligibility for a prior authorized patient will remain constant. If a client becomes ineligible for Medicaid benefits, the authorization becomes void.

6-003.01B3 Adult Emergency Dental Services / Extensive Treatment Circumstances: See 471 NAC 6-003.01C2 and 471 NAC 6-003.01C3 for service limitations. For planned services, the dental provider performing the service must complete and submit a prior authorization request form either by fax to (402) 742-8342 or mail (at the address in 6-003.01B1b) to the attention of the Dental Program Specialist. The request must clearly indicate that it is either an emergency services or extensive treatment circumstances request, and be accompanied by sufficient documentation to determine the emergent medical necessity. In the event that the service must be rendered immediately, the dental provider must submit a request for coverage, post treatment, with documentation of the emergent medical necessity, for payment review.

6-003.01C Services for Individuals Age 21 and Older: Dental coverage is limited to $1000 per fiscal year. The $1000 limit is calculated at the Medicaid dental fee schedule rate for the treatment provided or on the all inclusive encounter rate paid to Indian Health Service (IHS) or Federally Qualified Health Centers (FQHC) facilities.

6-003.01C1 Providers Responsibility and Client Responsibility Regarding the Yearly Dental Limit: Providers must inform a client before treatment is provided of the client's obligation to pay for a service if the client's annual limit has already been reached or if the amount of treatment proposed will cause the client's annual limit to be exceeded.

Also see 471 NAC 3-002.11, "Billing the Client".

6-003.01C2 Emergency Dental Services: Adult dental services provided in an emergency situation are not subject to the $1000 per fiscal year limits imposed in 471 NAC 6-003.01C. Adult dental services provided in an emergency situation will be considered for coverage on a case-by-case basis. Only the most limited service(s) needed to correct the emergency condition will be covered. Medicaid will cover emergency dental services that were not prior authorized. The provider must submit a completed coverage request with supporting documentation of the emergent nature of the services provided. Medicaid considers the following conditions to be emergent:

a. Extractions for the relief of:
   i. Severe and acute pain; or
   ii. An acute infections process in the mouth.
b. Extractions and necessary treatment for repair of traumatic injury;
c. Full mouth extractions as necessary for catastrophic illness such as an organ transplant, chemotherapy, severe heart disease, intra-oral radiation workup, or other life threatening illnesses.

6-003.01C3 Extensive Treatment Circumstances: Medicaid will review, and consider coverage of, services that cause the client to exceed the $1000 coverage limit, where the client is in need of extensive treatment in a hospital setting due to a disease/medical condition, or the client is disabled and it is in the best interest of the client's overall health to complete the treatment in a single setting. A prior authorization request must be submitted with medical necessity documentation.

6-003.01D Services Provided to Clients Enrolled in the Nebraska Medicaid Managed Care Program: See 471 NAC 1-002.01.

6-003.01E HEALTH CHECK (EPSDT) Treatment Services: See 471 NAC Chapter 33.

6-003.01F Hospitalization or Treatment in an Ambulatory Surgical Center: Dental services must be provided at the least expensive appropriate place of service. For clients enrolled in Managed Care, see 471 NAC 6-003.01D.

6-003.01G Medical and Surgical Services of a Dentist or Oral Surgeon: Medically necessary services of a Dentist or Oral Surgeon not otherwise covered in this Chapter, are covered and reimbursed as a Physician's Service in accordance with the 471 NAC Chapter 18. For clients enrolled in Managed Care see 471 NAC 6-003.01D.

6-003.02 Covered Services: Medicaid does not cover all American Dental Association (ADA) procedure codes. Covered codes are listed in the Medicaid Dental Fee Schedule in 471-000-506.

6-003.02A Diagnostic Services

6-003.02A1 Oral Evaluations: Oral evaluations are covered for new patients, emergency treatment, second opinions and specialists. All oral examinations must be

provided by a dentist. A single exam code is covered per date of service. Not to be billed with any other exam codes on the same date of service.

6-003.02A1a Periodic Oral Evaluations: Covered as follows:

6-003.02A1a(i) Age 20 & Younger: Periodic oral evaluation is covered once every 180 days.

6-003.02A1a(ii) Age 21 & Older: Periodic oral evaluation is covered once every 180 days.

6-003.02A1a(iii) Special Needs and Disabled Clients: Periodic oral evaluation is covered at the frequency determined appropriate by the treating dental provider.

6-003.02A1a(iv) Documentation Requirements: Documentation of client's special needs or disability is required.

6-003.02A1b Limited Oral Evaluation: Limited to twice in a one year period for each client, and for treatment of a specific oral health problem or complaint. Documentation which specifies the medical necessity is required.

6-003.02A1c Oral Evaluation for Infant: Covered for clients age 3 and younger, includes counseling with the primary caregiver.

6-003.02A1d Comprehensive Oral Evaluation: Benefit is limited to one per three year period per client and location. It is not payable in conjunction with emergency treatment visits, denture repairs or similar appointments.

6-003.02A1e Detailed and Extensive Oral Examination: Problem focused oral evaluation. Benefit is limited to one per three year period per client. It is not payable in conjunction with emergency treatment visits, denture repairs or similar appointments.

6-003.02A1f Re-Evaluation: Limited and problem focused. Benefit is limited to one per year per client.

6-003.02A1g Comprehensive Periodontal Evaluation: Benefit is limited to one per three year period per client.

6-003.02A2 Radiographs: Medicaid covers a "maximum dollar amount" for any combination of the following radiographs: Intraoral complete series, intraoral periapical films, extraoral films, bitewings, or panorex. The maximum dollar amount covered is equal to the Medicaid fee paid for an intraoral complete series (see Appendix 471-000-72). A Cephalometric film is not included in the maximum dollar amount. Occlusal film (2 ¼ X 3 ¼ size): Medicaid covers:

a. Bitewings: A maximum of four bitewings per date of service.
b. Intraoral Complete Series: Covered every three years.

c. Panorex: Covered every three years. Covered more frequently if necessary for treatment.
   i. Documentation Requirements: Document need for more frequent panorex in dental chart.
d. Cephalometric film: Covered for clients age 20 and younger, as follows:
   i. Orthodontic Treatment: Covered if the client will qualify for Medicaid coverage of treatment as outlined in the Orthodontic coverage criteria (see 471 NAC 6-003.02G).

6-003.02A3 Diagnostic Casts: Covered for clients age 20 and younger as follows:
a. Orthodontic Treatment: Covered if the client will qualify for Medicaid coverage of treatment as outlined in the Orthodontic coverage criteria (see 471 NAC 6-003.02G).

6-003.02B Preventive Services

6-003.02B1 Prophylaxis: Prophylaxis procedures are covered at the frequency listed below:

6-003.02B1a Age 13 and younger - Covered one time every 180 days. Bill as a child prophylaxis

6-003.02B1b Age 14 through 20 - Covered every 180 days. Bill as an adult prophylaxis

6-003.02B1c Age 21 and Older - Covered one time every 180 days.

6-003.02B1d Special Needs Clients: Prophylaxis is covered at the frequency determined appropriate by the treating dental provider. Limited to one per date of service per client.

6-003.02B1d(i) Documentation Requirements: Documentation of client's special needs or disability is required.

6-003.02B2 Topical Fluoride and Fluoride Varnish: Covered for adults and children at the frequency determined appropriate by the treating dental provider.

6-003.02B3 Sealants: Covered on permanent and primary teeth for clients ages 20 and younger. Covered once per tooth every 730 days.

6-003.02B4 Space Maintainers (Passive Appliances): Covered for clients age 20 and younger. Covered once every 365 days.

6-003.02B5 Recementation of Space Maintainers: Covered for clients age 20 and younger. Covered once every 365 days.

6-003.02C Restorative Services: Tooth preparation, temporary restorations, cement bases, pulp capping, impressions and local anesthesia are included in the restorative fee for each covered service.

6-003.02C1 Amalgam or Resin: Resin refers to a broad category of materials including but not limited to composites, and glass ionomers. Full Labial veneers for cosmetic purposes are not covered.

6-003.02C1a Documentation Requirements: Documentation of carious lesions must be present.

6-003.02C1b Maximum Fee: A maximum fee is covered per tooth for any combination of amalgam or resin restoration procedure codes. The maximum fee is equal to the Medicaid fee for a four or more surface restoration.

6-003.02C2 Crowns: Covered for anterior and bicuspid teeth when other restoration is not possible. Covered for molar teeth that have been endodontically treated, and cannot be adequately restored with a stainless steel crown, amalgam or resin restoration. Not covered for third molars. A replacement crown for the same tooth in less than 1,825 days, due to failure of the crown, is not covered and is the responsibility of the dentist who originally placed the crown.

6-003.02C2a Documentation Requirements: Submit x-ray of anterior and/or bicuspids, or x-ray of molar that shows completed root canal. A request should not be submitted for unusual or exceptional situations not covered herein.

6-003.02C3 Prefabricated Stainless Steel Crowns: Covered for primary and permanent teeth.

6-003.02C4 Prefabricated Stainless Steel Crown with Resin Window: Covered for primary anterior teeth.

6-003.02C5 Sedative Filling: Covered once per tooth every 365 days.

6-003.02C6 Unspecified Restorative Procedure, By Report: Used for procedures that are not adequately described by another code. This code shall not be used to claim an item that has an ADA code, but is not covered by Medicaid.

6-003.02C6a Documentation Requirements: A description of treatment provided must be submitted with the claim. This service is reviewed prior to payment.

6-003.02D Endodontics:

6-003.02D1 Therapeutic Pulpotomy and Pupal Therapy: Covered for primary teeth only. Not covered for permanent teeth.

6-003.02D2 Root Canal Therapy and Re-treatment of Previous Root Canals: Covered for permanent teeth. Root canal treatment includes a treatment plan, necessary appointments, clinical procedures, radiographic images and follow up care. Re-treatment of previous root canals may be covered if at least 365 days have passed since the original treatment, and failure has been demonstrated with x-ray documentation and narrative summary.

6-003.02D2a Limitations: Not covered for third molars.

6-003.02D2b Documentation Requirements: Post-op x-ray of completed root canal must be available for review by Department upon request.

6-003.02D3 Apicoectomy: Covered on permanent anterior teeth.

6-003.02D4 Emergency Treatment to Relieve Endodontic Pain: Covered as "Unspecified Endodontic Procedure, By Report" code. Tooth number must be identified on the claim submission. Not to be submitted with any other definitive treatment codes on same tooth on same day of service.

6-003.02E Periodontics:

6-003.02E1 Gingivectomy or Gingivoplasty Per Tooth or Per Quadrant

6-003.02E2 Periodontal Scaling and Root Planing: Medicaid covers four quadrants of scaling and root planning once every 365 days. Each quadrant is covered one time per client. The request for approval must be accompanied by the following:

i. A periodontal treatment plan;
ii. A completed copy of a periodontic probe chart that exhibits pocket depths;
iii. A periodontal history, including home oral care; and
iv. Radiography.

6-003.02E2a Exclusions: For scaling and root planning that requires the use of local anesthesia, NE Medicaid does not cover more than one half of the mouth in one day, except on hospital cases.

6-003.02E2b Documentation Requirements: Submit with prior authorization request:

i. Periapical x-rays demonstrating subgingival calculus and/or loss of crestal bone; and
ii. Periodontal probe chart evidencing active periodontal disease and pocket depths of 4mm or greater.

A treatment plan that demonstrates that curettage, scaling, or root planning is required in addition to a routine prophylaxis.

6-003.02E3 Full Mouth Debridement: Medicaid covers one full mouth debridement procedure every 365 days per client. Not covered on the same date of service as prophylaxis.

6-003.02E4 Periodontal Maintenance Procedure: Covered for clients that have had Medicaid approved periodontal scaling and root planing. Prior authorization must be renewed annually.

6-003.02E4a Documentation Requirements: Submit with prior authorization request:

i. Date the Medicaid approved scaling and root planing completed;
ii. Periodontal history; and,
iii. Frequency the dental provider is requesting that the client must be seen for maintenance procedure.

6-003.02F Prosthodontics: Medicaid covers the following prosthetic appliances, subject to service specific coverage criteria.

i. Dentures (immediate, replacement/complete, or interim/complete);
ii. Resin base partial dentures, including metal clasps;
iii. Flipper partials (considered a permanent replacement of one to three anterior teeth only); and
iv. Cast metal framework with resin denture base partials, covered for clients age 20 and younger.

Coverage of prosthetic appliances includes all materials, fitting and placement of the prosthesis, and all necessary adjustments for a period of 180 days following placement of the prosthesis.

6-003.02F1 Replacement: Replacement of any prosthetic appliance is covered once every five years when:

a. The client's dental history does not show that previous prosthetic appliances have been unsatisfactory to the client; and
b. The client does not have a history of lost prosthetic appliances; and
c. A repair will not make the existing denture or partial functional; or
d. A reline will not make the existing denture or partial functional; or
e. A rebase will not make the existing denture or partial functional.

Medicaid covers a one time replacement within the 5 year coverage limit for broken/lost/stolen appliances. This one time replacement is available once within each client’s lifetime, and a prior authorization request must be submitted and marked as a one time replacement request.

6-003.02F2 Complete Dentures (Maxillary and Mandibular): Covered 180 days after placement of interim dentures. Relines, rebases and adjustments are not billable for 180 days after placement of the prosthesis.

6-003.02F2a Documentation Requirements: Submit with prior authorization request:

i. Date of previous denture placement;
ii. Information on condition of existing denture; and
iii. For initial placements, submit panorex or full mouth series radiographs.

6-003.02F3 Immediate Dentures (Maxillary and Mandibular): Considered a permanent denture. Relines or rebases are not billable for 180 days after placement of the prosthesis.

6-003.02F3a Documentation Requirements: Submit with prior authorization request:

i. Date and list of teeth to be extracted;
ii. Narrative documenting medical necessity; and
iii. Submit panorex or full mouth series radiographs.

6-003.02F4 Partial Resin Base (Maxillary or Mandibular): Covered if the client does not have adequate occlusion. Cast metal clasps are included on partial dentures. One to three missing anterior teeth should be replaced with a flipper partial which is considered a permanent replacement.

6-003.02F4a Documentation Requirements: Submit with prior authorization request:

i. Chart or list of missing teeth and/or teeth to be extracted;
ii. Age and condition of any existing partial, or a statement identifying the prosthesis as an initial placement;
iii. Narrative documenting how there is not adequate occlusion; and
iv. For initial placements, radiographs of remaining teeth are required.

6-003.02F5 Partial Cast Metal Base (Maxillary or Mandibular): Covered for clients age 20 and younger only. More than one posterior tooth must be missing for partial placement. One to three missing anterior teeth should be replaced with a flipper partial which is considered a permanent replacement.

6-003.02F6 Adjustments – Dentures and Partials: Not covered for 180 days following placement of a new prosthesis. Adjustments after 180 days are billable as needed to make prosthesis wearable.

6-003.02F7 Repairs to Dentures and Partials: Medicaid covers 2 repairs per prosthesis every 365 days.

6-003.02F8 Rebase of Dentures and Partials: Covered following the placement of a new prosthesis after 180 days have passed. Covered once per prosthesis every 365 days. Chairside and lab rebases are covered, but only one can be provided within the 365 day period.

6-003.02F9 Reline of Dentures and Partials: Covered following the placement of a new prosthesis after 180 days have passed. Covered once per prostheses every 365 days. Chairside and lab relines are covered, but only one can be provided within the 365 day period.

6-003.02F10 Interim Complete Dentures (Maxillary and Mandibular): Interim dentures can be replaced with a complete denture 180 days after placement of the interim denture. Complete dentures require prior authorization in accordance with 471 NAC 6-003.01B(iv) and are regulated under 471 NAC 6-003.02E2.

6-003.02F10a Documentation Requirements: Submit with prior authorization request:

i. Date and list of teeth to be extracted;
ii. Narrative documenting medical necessity; and
iii. Submit panorex or full mouth series radiographs.

6-003.02F11 Flipper Partial Dentures (Maxillary and Mandibular): Considered a permanent replacement for one to three anterior teeth. Not covered for temporary replacement of missing teeth. Relines, rebases and adjustments are not billable for 180 days after placement of the prosthesis.

6-003.02F11a Documentation Requirements: Submit with prior authorization request:

i. Chart or list missing teeth and/or teeth to be extracted;
ii. Age and condition of existing partials, or a statement identifying the prosthesis as an initial placement; and,
iii. Radiographs.

6-003.02F12 Tissue Conditioning: Covered one time during the first 180 days following placement of a prosthetic appliance. Following the initial 180 days, necessary tissue conditioning may be covered two times per prosthesis every 365 days, with documentation in the dental record.

6-003.02G Oral and Maxillofacial Surgery

6-003.02G1 Extractions Routine and Surgical: Medicaid covers necessary extraction of teeth when there is documented medical need for the extraction. The Medicaid fee for extractions includes local anesthesia, suturing if needed, and routine postoperative care.

6-003.02G1a Documentation Requirements: Document the medical reason for extractions in the dental chart.

6-003.02G2 Tooth Reimplantation and/or Stabilization of an Accidentally Evulsed or Displaced Tooth and or Alveolus: The Medicaid fee includes splinting and/or stabilization.

6-003.02G3 Surgical Exposure of Impacted or Unerupted Tooth for Orthodontic Reasons: The Medicaid fee includes the orthodontic attachment.

6-003.02G4 Biopsy of Oral Tissue (Hard or Soft): The Medicaid fee is for the professional component only. The lab must bill the specimen charge.

6-003.02G5 Alveoloplasty: The Medicaid fee for extractions includes routine recontouring of the ridge and/or suturing as necessary. It is not a separate billable procedure.

6-003.02G5a Alveoloplasty In Conjunction With Extractions: Covered per quadrant as a separate procedure when it is necessary beyond routine recontouring to prepare the ridge for a prosthetic appliance.

6-003.02G6 Excisions: See 471 NAC 6-004.01B3

6-003.02G7 Occlusal Orthotic Device, By Report: The fee includes any necessary adjustments. For treatment of bruxism or for minor occlusal problems, see Occlusal Guard on 471 NAC 6-003.02H8.

6-003.02G7a Documentation Requirements: Document the type of appliance made, and medical necessity.

6-003.02H Orthodontics: Medicaid covers prior authorized (see 471 NAC 6-003.01B(vii) orthodontic treatment for clients who are age 20 or younger, and have a handicapping malocclusion.

6-003.02H1 Coverage Criteria for Diagnostic Models and Radiographs: Diagnostic records are not covered by Medicaid unless the case will qualify for Medicaid coverage as outlined in this (471 NAC 6-003.02G) section. Diagnostic records for minor malocclusions are not covered by Medicaid.

For auditing purposes, Medicaid may request end of treatment diagnostic models and x-rays. Payment for the end of treatment records will be included in the dollar amount prior authorized (see 471 NAC 6-004.02B4). The end of treatment records shall be submitted to the Department for review by the dental consultant.

6-003.02H2 Forms: Appendix 471-000-406 contains an orthodontic Handicapping Labiolingual Deviation (HLD) form that shall be used to pre-screen orthodontic cases. This appendix also includes request forms that shall also be used to submit prior authorization requests for orthodontic treatment.

6-003.02H3 Orthodontic Treatment: To be eligible for orthodontic treatment, a client must be age 20 or younger when treatment is authorized, have a handicapping malocclusion (see 471 NAC 6-001), which includes one or more of the following five documented conditions:

i. Accident causing a severe malocclusion;
ii. Injury causing a severe malocclusion;
iii. Condition that was present at birth causing a severe malocclusion;
iv. Medical condition causing a severe malocclusion; and
v. Facial skeletal condition causing a severe malocclusion.

When the individual has had a surgical correction (cleft lip or palate, or orthognathic correction), the monthly adjustment procedure is reimbursed at a higher fee. The pre-treatment request must contain documentation of the client's medical condition, or surgical correction.

Treatment is prior authorized and paid on a single procedure code. The authorized code will be on the MC-9D prior authorization form (Appendix 471-000-201) or the ASC X 12N 278. In order for Medicaid clients to receive timely treatment, the request for approval shall constitute the providers acceptance of the Medicaid fee, and a commitment to complete care.

6-003.02H3a Documentation Requirements: The following documentation must be submitted with the prior authorization request.

i. A pre-treatment request form that outlines treatment to be completed and the Handicapping Labiolingual Deviation (HLD) Index Form in appendix 471-000-406;
ii. Diagnostic records:
    1) Diagnostic casts and/or Oral/facial photographic images;
    2) Full mouth radiographs and/or Panoramic x-ray; and
    3) Cephalometric x-ray.
iii. A narrative description of the diagnosis, and prognosis; and,
iv. On surgical cases include a description of the procedure to be completed. Following completed surgery, a surgical letter of documentation is required accompanying an additional prior authorization request for the added surgical fee.

6-003.02H4 Interceptive Orthodontic Treatment of Transitional Dentition: Covered if cost effective to lessen the severity of a malformation such that extensive treatment is not required.

6-003.02H5 Removable and Fixed Appliance Therapy (thumb sucking and tongue thrust): Covered for clients age 20 and younger, includes adjustments.

6-003.02H6 Repair of Orthodontic Appliances: Covered for clients age 20 and younger.

6-003.02H6a Documentation Requirements: Include a description of the repair on the dental claim, and in the dental chart.

6-003.02H7 Orthodontic Retainers (Replacement): Covered for clients age 20 and younger if the client is compliant with wearing the appliance.

6-003.02H8 Repair of Bracket and Standard Fixed Orthodontic Appliances: Covered for clients age 20 and younger, when repairs exceed routine repairs associated with orthodontic treatment.

6-003.02I Adjunctive General Services

6-003.02I1 Palliative Treatment: Palliative treatment is covered once per date of service per location. Examples of palliative treatment are treatment of soft tissue infection; smoothing a fractured tooth. Exception: Palliative treatment on a specific tooth is not covered if definitive treatment (e.g. restorative or endodontic treatment) was provided on the same tooth for the same date of service.

6-003.02I1a Documentation Requirements: Document the palliative treatment provided on or in the dental claim, and in the dental chart.

6-003.02I2 General Anesthesia: General anesthesia administered in the provider's office is covered when it is medically necessary to treat the client. Administration of general anesthesia must be performed in full compliance with Neb. Rev. Stat. §38-101 to §38-1140.

6-003.02I2a Documentation Requirements: Document in the dental chart the medical necessity for the anesthesia. An appropriate sedation record must be maintained, including the names of all drugs administered, including local anesthetics, dosages, and monitored vital signs.

6-003.02I3 Analgesia, Anxiolysis, Inhalation of Nitrous Oxide: Covered when medically necessary to treat the client.

6-003.02I4 Intravenous Sedation/Analgesia: Intravenous sedation/analgesia administered in the provider's office or location is covered when it is medically necessary to treat the client.

6-003.02I4a Documentation Requirements: Document in the dental chart the medical need for the anesthesia. An appropriate sedation record must be maintained, including the names of all drugs administered, including local anesthetics, dosages, and monitored vital signs.

6-003.02I5 Non-Intravenous Conscious Sedation: Non-intravenous conscious sedation administered in the provider's office is covered when it is medically necessary to treat the client. The use of oral medications require monitoring.

6-003.02I5a Documentation Requirements: Document in the dental chart the medical need for the anesthesia. An appropriate sedation record must be maintained, including the names of all drugs administered, including local anesthetics, dosages, and monitored vital signs.

6-003.02I6 House Call, (Nursing Facility Call), Hospital Call, Ambulatory Surgical Center (ASC) Call: Covered one per day per facility regardless of the number of patients seen.

6-003.02I6a Documentation Requirements: Document on or in the dental claim the name of the facility, or home address where treatment was provided.

6-003.02I7 Office Visit – After Regularly Scheduled Hours: Covered in addition to an exam and treatment provided, when treatment is provided after normal office hours.

6-003.02I8 Occlusal Guard: Covered once every 1095 days to minimize the effects of bruxism and other occlusal factors. Occlusal guards are removable appliances. Athletic guards are not covered.

6-003.02I8a Documentation Requirements: Document the medical necessity for the occlusal guard in the dental chart. Documentation should support evidence of significant loss of tooth enamel or tooth chipping, or the medical documentation supports headaches and/or jaw pain.

6-003.03 Non-Covered Services: Medicaid does not cover any service that is:

1. cosmetic;
2. more costly than another, equally effective available service;
3. not within the coverage criteria of these regulations;
4. determined not medically necessary by the Department; or
5. experimental, investigational, or non-FDA approved.

6-004 Billing and Payment for Dental Services

6-004.01 Billing

4-004.01A General Billing Requirements: Providers shall comply with all applicable billing requirements codified in 471 NAC Chapter 3. In the event that billing requirements in 471 NAC Chapter 3 conflict with billing requirements outlined in this 471 NAC Chapter 6, the billing requirements in 471 NAC Chapter 6 shall govern.

6-004.01B Specific Billing Requirements

6-004.01B1 Billing Instructions: The Provider shall bill Medicaid using the procedure codes outlined in the Nebraska Medicaid Dental Fee Schedule (Appendix 471-000-506), and in accordance with the billing instruction included in Appendix 471-000-88. The fees listed on the dental claim must be the dentist's usual and customary charge for each procedure code.

6-004.02 Payment

6-004.02A General Payment Requirements: Nebraska Medicaid will reimburse the Provider for services rendered in accordance with the applicable payment regulations codified in 471

NAC Chapter 3. In the event that individual payment regulations in 471 NAC Chapter 3 conflict with payment regulations outlined in this 471 NAC Chapter 6, the individual payment regulations in 471 NAC Chapter 6 shall govern.

6-004.02B Specific Payment Requirements

6-004.02B1 Reimbursement: Medicaid pays for covered dental services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule (Appendix 471-000-506) in effect for that date of service.

6-004.02B2 Restorative Services Rates: Operative dentistry fee includes local anesthetic, bases, or insulation and other procedures necessary to complete the case. Pins are billed separately.

6-004.02B3 Payment for Interceptive and Comprehensive Orthodontic Treatment: Payment for authorized orthodontic treatment is made upon approval of the treatment plan and submittal of a dental claim.

6-004.02B3a Transfer of Interceptive and Comprehensive Orthodontic Cases: If the client transfers to another dentist, the dentist who obtained the original authorization and initiated orthodontic treatment, shall refund to Medicaid the portion of the amount paid by Medicaid that applies to the treatment not completed. The transfer request must be submitted and reviewed by the Dental Consultant to determine the amount to be refunded. Transfers are only allowed under hardship circumstances; i.e. Travel distances.

6-004.02B3b Interceptive and Comprehensive Orthodontic Treatment Not Completed: If prior authorized orthodontic treatment is not completed, the dentist who obtained the original authorization and initiated the treatment shall refund to Medicaid the portion of the amount paid by Medicaid that applies to the treatment not completed. The request to discontinue treatment must be submitted and reviewed by the Dental Consultant to determine the amount to be refunded.

6-004.02B4 Audit Records: Medicaid may request end of treatment diagnostic models and x-rays in accordance with 471 NAC 6-003.02G1. Payment for the end of treatment records is included in the dollar amount prior authorized.

6-004.02B5 Supplemental Payments: See Appendix 471-000-506.

CHAPTER 6-000 DENTAL SERVICES

6-001 Introduction: The Nebraska Medical Assistance Program (NMAP), also known as Medicaid, provides coverage of dental services as outlined in this chapter. Medicaid pays for these dental services when they are:

1. Provided to an individual who is Medicaid eligible on the day that they receive the service; and
2. Dentally necessary; and
3. Treatment provided is the least costly service meeting the treatment needs; and
4. Reasonable in amount and duration of care, treatment or service; and
5. Within the scope of the coverage criteria contained in these regulations; and
6. Within accepted dental or medical practice standards; and
7. Consistent with a diagnosis of dental disease or condition.

Services are subject to the specific limitations or prior authorization requirements as listed in 471 NAC 6-005. Documentation of medical and dental need is required on some procedures. The documentation should be in the client's dental chart which must be available upon request to the Department.

Information on how to request prior authorization is in 471 NAC 6-004.

6-002 Covered Services: NMAP covers medically necessary and appropriate dental services within program regulations.

6-003 Non-Covered Services: NMAP does not cover any procedure that is:

1. Cosmetic; or
2. More costly services when less costly, equally effective services are available, or
3. Services that are not within the coverage criteria of these regulations; or
4. Services that are determined not medically necessary by the Department; or
5. Services that are determined not dentally necessary by the Department.

6-004 How to Request Prior Authorization: To request prior authorization for a proposed dental pre-treatment plan, the dentist must submit the request electronically using the standard Health Care Services Review – Request for Review and Response transaction (ASC X12N 278) or submit a dental claim form and required documentation to:

Department of Health and Human Services
Division of Medicaid and Long Term Care
P. O. Box 95026
Lincoln, NE 68509-5026

Inadequate information may cause the treatment plan to be disapproved, or returned for additional information.

6-005 NMAP Covered Services, Coverage Limitations, Prior Authorization Requirements:
NMAP does not cover all American Dental Association (ADA) procedure codes. Covered codes are listed in the Nebraska Medicaid Dental Fee Schedule in 471-000-506.

6-005.01 Services for Individuals Age 21 and Older: Dental coverage is limited to $1000 per fiscal year. The $1000 limit is calculated at the Medicaid dental fee schedule rate for the treatment provided or on the all inclusive encounter rate paid to Indian Health Service (IHS) or Federally Qualified Health Centers (FQHC) facilities.

6-005.01A Providers Responsibility and Client Responsibility Regarding the Yearly Dental Limit: Providers must inform a client before treatment is provided of the client's obligation to pay for a service if the client's annual limit has already been reached or if the amount of treatment proposed will cause the client's annual limit to be exceeded.

A client must inform a provider in advance of receiving treatment if a portion of his/her annual dental benefit amount has already been expended.

Also see 471 NAC 3-002.11, "Billing the Client".

Service Description	NMAP Coverage/Limitations	Prior Authorization Required
DIAGNOSTIC		
Oral Evaluations	A periodic oral evaluation is covered at the frequency listed below: Age 20 & Younger: Routine periodic oral evaluation is covered once every six months. May be seen more frequently if determined necessary by treating dentist. Age 21 & Older: Routine periodic oral evaluation is covered once every twelve months. Age 21 & Older with Special Needs: Routine periodic oral evaluation is covered at the frequency determined appropriate by the treating dentist. A client with special needs is a client who is unable to care for his/her mouth properly on his/her own because of a disabling condition or a pregnant woman. Note – All Clients: Oral evaluations are covered for new patients, emergency treatment, second opinions and specialists. Documentation Requirements: Document client's special needs in dental chart.	No
Radiographs	NMAP covers a "maximum dollar amount" for any combination of the following radiographs: Intraoral complete series, intraoral periapical films, extraoral films, bitewings, or panoramic film. The maximum dollar amount covered is equal to the Medicaid fee paid for an intraoral complete series. The amount is in Appendix 471-000-72. A Cephalometric film is not included in the maximum dollar amount. Occlusal film is 2 ¼ X 3 ¼ size NMAP covers: Bitewings: A maximum of four bitewings per date of service. Intraoral Complete Series: Covered every three years. Panoramic Film: Covered every three years on routine basis. Covered more frequently if necessary for treatment. Documentation Requirements: Document need for more frequent panorex in dental chart.	No

Services Description	NMAP Coverage/Limitations	Prior Authorization Required
Radiographs	Cephalometric film: Covered for clients age 20 and younger as follows: 1. Orthodontic Treatment: Covered to diagnose if the treating dentist believes through visual exam that the case will qualify for Medicaid coverage of treatment as outlined on page 11 of 14.	No
Diagnostic Casts	Covered for clients age 20 and younger as follows: 1. Orthodontic Treatment: Covered to diagnose if the treating dentist believes through visual exam that the case will qualify for Medicaid coverage of treatment as outlined on Page 11 of 14.	No
PREVENTIVE:		
Prophylaxis	Prophylaxis procedures are covered at the frequency listed below: Age 13 and younger - Covered at the frequency determined appropriate by the treating dentist with a six-month prophylaxis considered the standard. BILL AS A CHILD PROPHYLAXIS Age 14 through 20 - Covered at the frequency determined appropriate by the treating dentist with a six-month prophylaxis considered the standard. BILL AS AN ADULT PROPHYLAXIS Age 21 and Older - Covered one time per year. Clients Age 21 and Older with Special Needs: Prophylaxis is covered at the frequency determined appropriate by the treating dentist. A client with special needs is a client who is unable to care for their mouth properly on their own because of a disabling condition, or a pregnant woman. Documentation Requirements: Document client's special needs in dental chart.	No
Topical Fluoride	Covered for adults and children at the frequency determined appropriate by the treating dentist.	No
Sealants	Covered on permanent and primary teeth, children and adults. A re-seal is not covered more often than every two years.	No
Space Maintainers (Passive Appliances)	Covered for clients age 20 and younger.	No
Recementation of space maintainers	Covered for clients age 20 and younger.	No

Services Description	NMAP Coverage/Limitations	Prior Authorization Required
RESTORATIVE:		
	Operative dentistry fee includes local anesthetic, bases, or insulation and other procedures necessary to complete the case. Pins are billed separately.	
Amalgam or Resin	Resin refers to a broad category of materials including but not limited to composites, and glass ionomers. Full Labial veneers for cosmetic purposes are not covered. Documentation of carious lesions must be present. A maximum fee is covered per tooth for any combination of amalgam or resin restoration procedure codes. The maximum fee is equal to the Medicaid fee for a four or more surface restoration.	No
Crowns – Resin	Covered for anterior teeth.	Yes Documentation Requirements: Submit x-rays with prior authorization request.
Crowns – Porcelain	Covered for anterior and bicuspid teeth when conventional restoration is not possible. Covered for molar teeth that have been endodontically treated that can not be adequately restored with a stainless steel crown, amalgam or resin restoration.	Yes Documentation Requirements: Submit x-rays with prior authorization request.
Recement inlay		No
Recement crown		No
Prefabricated Stainless Steel Crowns	Covered for primary and permanent teeth.	No
Prefabricated Stainless Steel Crown with Resin Window	Covered for primary anterior teeth.	No

Services Description	Medicaid Coverage/Limitations	Prior Authorization Required
Sedative filling		No
Core buildup, including any pins		No
Pin retention		No
Prefabricated Post and Core in Addition to Crown		No
Temporary crown		No
Crown repair		No
Unspecified Restorative Procedure, By Report	Documentation Requirements: A description of treatment provided must be submitted on or in the dental claim. This service is reviewed prior to payment.	No
Therapeutic Pulpotomy and Pupal Therapy	Covered for primary teeth. Not covered for permanent teeth.	No
Root Canal Therapy and Re-treatment of Previous Root Canals	Covered for permanent teeth. Age 19 and older: Not covered for maxillary 2nd molar if 1st molar is in occlusion. Documentation Requirements: Post-op x-ray of completed root canal must be available for review by Department upon request.	No
Apicoectomy	Covered on permanent anterior teeth.	No
Emergency Treatment to Relieve Endodontic Pain	Bill on "Unspecified Endodontic Procedure, By Report" code.	No
PERIODONTICS:		
Gingivectomy or Gingivoplasty per tooth or per quadrant		No

Services Description	NMAP Coverage/Limitations	Prior Authorization Required
Periodontal Scaling and Root Planing	Four quadrants of scaling and root planing are covered one time per client when the following criteria is met: 1. The client is pregnant; or 2. The client has a serious or life threatening medical condition that may be affected by untreated periodontal disease; or 3. The following criteria is met; a. The client is an established patient in the dentist office, and does not seek treatment only for emergency care; and b. The client is doing adequate home care and maintains good oral hygiene; and c. The client exhibits an interest in maintaining their dental structure. Scaling and root planing is not covered if the patient is not compliant with home care within the patient's skill or ability. An established patient is defined as a patient that has been seen in the dental office for two consecutive yearly recall appointments. Scaling and root planing requires the use of local anesthesia. NMAP does not cover scaling and root planing of more than one half of the mouth in one day except on hospital cases.	Yes Documentation Requirements: Submit with prior authorization request: 1. P.A. x-rays 2. Perio Charting 3. Health history and medical information about the client. 4. Information on how long a patient in dental office. 5. Information on home care.
Full Mouth Debridement	Covered in addition to a prophylaxis procedure. Clients with Special Needs: NMAP covers one full mouth debridement procedure (maximum 1) and one prophylaxis procedure per quadrant (maximum of 4) for clients that have special needs. Special need clients are clients with mental retardation, or clients that must be treated in a hospital outpatient or ambulatory surgical center setting (ASC). Documentation Requirements: Document the client's special needs in the dental chart.	No

Services Description	NMAP Coverage/Limitations	Prior Authorization Required
Periodontal Maintenance Procedure	Covered for clients that have had periodontal scaling and root planing, and are compliant with home care within their abilities. Client should be put on yearly recall if treatment needs change.	Yes Documentation Requirements: Submit with prior authorization request: 1. Date scaling and root planing completed. 2 Health history and medical information about the client. 3. Frequency client must be seen for maintenance procedure.

PROSTHODONTICS

Medicaid covers the following prosthetic appliances when coverage criteria is met.
1. Dentures (immediate, replacement/complete, or interim/complete)
2. Resin base partial dentures;
3. Flipper partials (considered a permanent replacement)
4. Cast metal framework with resin denture base partials, covered for clients age 20 and younger.

Material used must be of a quality that with normal wear, the prosthetic appliance will last a minimum of five years.

A complete prosthetic appliance case includes all materials and necessary adjustments for a period of six months following placement of the prosthesis.

Replacement prosthetic appliances are covered when:
1. The client's dental history does not show that previous prosthetic appliances have been unsatisfactory to the client; and
2. The client does not have a history of lost prosthetic appliances; and
3. A repair will not make the existing denture or partial wearable; or
4. A reline will not make the existing denture or partial wearable; or
5. A rebase will not make the existing denture or partial wearable; or

Prior authorization requirements and procedure specific coverage criteria is listed below.

Services Description	NMAP Coverage/Limitations	Prior Authorization Required
Complete Dentures (Maxillary and Mandibular)	Covered six months after placement of treatment/interim dentures or as replacement of existing complete dentures that is no longer wearable and cannot be made wearable. Relines, rebases and adjustments are not covered for six months after placement of the prosthesis.	Yes Documentation Requirements: Submit with prior authorization request: 1. Date of previous denture placement. 2 Information on condition of existing denture.
Immediate Dentures (Maxillary and Mandibular)	Considered a permanent denture. Relines or rebases are not covered for six months after placement of the prosthesis.	No
Maxillary Partial Resin Base Mandibular Partial Resin Base	Adequate occlusion for partial dentures is defined as first molar to first molar, or a similar combination of anterior and posterior teeth on the upper or lower arch in occlusion. More than one posterior tooth must be missing for placement of partials. Cast clasps must be used on partial dentures. One to three missing anterior teeth should be replaced with a flipper partial which is considered a permanent replacement.	Yes Documentation Requirements: Submit with prior authorization request: 1. Chart or list missing teeth and teeth to be extracted. 2. Age of any existing partial. 3. Information on condition of existing partial. Yes
Maxillary Partial Cast Metal Base Mandibular Partial Cast Metal Base	Not covered for clients age 21 and Older. Covered for clients age 20 and younger. Adequate occlusion for partial dentures is defined as first molar to first molar, or a similar combination of anterior and posterior teeth on the upper or lower arch in occlusion. More than one posterior tooth must be missing for partial placement. One to three missing anterior teeth should be replaced with a flipper partial which is considered a permanent replacement.	No No
Adjustments – Dentures and Partials	Not covered for six months following placement of a new prosthesis. Adjustments after six months are covered as needed to make prosthesis wearable.	No
Repairs to Dentures and Partials	Covered as needed to make existing prosthetic appliances wearable.	No

Services Description	NMAP Coverage/Limitations	Prior Authorization Required
Rebase of Dentures and Partials	Not covered for six months following the placement of a new prosthesis. After six months, covered as necessary to make existing prosthetic appliance wearable.	No
Reline of Dentures and Partials	Not covered for six months following the placement of a new prosthetic appliance. After six months, covered as necessary to make existing prosthetic appliance wearable. Chairside and lab relines are covered.	No
Interim Dentures (Maxillary and Mandibular)	Interim dentures can be replaced with a complete denture six months after placement of the interim denture. Complete dentures require prior authorization.	No
Flipper Partial Dentures (Maxillary and Mandibular)	Considered a permanent replacement for one to three anterior teeth. Not covered for temporary replacement of missing teeth. Relines, rebases and adjustments are not covered for 6 months after placement of the prosthesis.	Yes Documentation Requirements: Submit with prior authorization request: 1. Chart or list missing teeth and teeth to be extracted. 2. Age of existing partials. 3. Information on condition of existing partial.
Tissue Conditioning	Covered one time during the first six months following placement of a prosthetic appliance. Necessary tissue conditioning may be covered at other times with documentation in the dental record.	No
Recement fixed partial denture		No

Services Description	NMAP Coverage/Limitations	Prior Authorization Required
ORAL AND MAXILLOFACIAL SURGERY		
Extractions Routine and Surgical	NMAP covers necessary extraction of teeth when there is documented medical need for the extraction. Consideration should be given to retaining third molars that could be used in the future as supplement to occlusion if other molars are missing, or for abutment teeth for prosthetic appliances. Documentation Requirements: Document the medical reason for extractions in the dental chart. The Medicaid fee for extractions includes local anesthesia, suturing if needed, and routine postoperative care.	No
Tooth Reimplantation and/or Stabilization of an Accidentally Evulsed or Displaced Tooth and or Alveolus	The Medicaid fee includes splinting and/or stabilization.	No

Services Description	NMAP Coverage/Limitations	Prior Authorization Required
Surgical Exposure of Impacted or Unerupted Tooth for Orthodontic Reasons	The Medicaid fee includes the orthodontic attachment.	No
Biopsy of Oral Tissue (Hard or Soft)	The Medicaid fee is for the professional component only. The lab must bill the specimen charge.	No
Alveoloplasty	The Medicaid fee for extractions includes routine recontouring of the ridge and/or suturing as necessary. It is not a separate billable procedure. Alveoloplasty in conjunction with extractions – per quadrant is covered as a separate procedure when it is necessary beyond routine recontouring to prepare the ridge for a prosthetic appliance.	No
Excisions	Excisions may be billed on a dental claim or using the standard Health Care Claim: Dental transaction (ASC X12N 837) with CDT codes, or on Form CMS-1500 or electronically using the standard Health Care Claim: Professional transaction (ASC X12N 837) with HCPCS/CPT codes. If billing on Form CMS-1500 or electronically using the standard Health Care Claim: Professional transaction (ASC X12N 837), see 471 NAC 6-009 regarding "Services Provided to Clients Enrolled in the Nebraska Medicaid Managed Care Program, Nebraska Health Connection (NHC.)	No
Occlusal Orthotic Device, By Report	Occlusal orthotic devices are defined as splints that are provided for treatment of temporomandibular joint dysfunction. The fee includes any necessary adjustments. For treatment of bruxism or for minor occlusal problems, see Occlusal Guard on 471 NAC 6-005, page 14 of 14. Documentation Requirements: Document the type of appliance made and medical condition on or in the claim.	No

ORTHODONTICS

Orthodontic treatment requires prior authorization and is covered for clients age 20 and younger. The client must be age 20 or younger when treatment is authorized, and the client must have a handicapping malocclusion as defined in the orthodontic service description section.

Coverage Criteria for Diagnostic Models and Radiographs:

1. Orthodontic Cases: Diagnostic records are not covered by Medicaid unless the treating dentists, through a visual exam, feels that the case will qualify for Medicaid coverage as defined in the "Orthodontic Treatment" section. Diagnostic records for minor malocclusions are not covered by NMAP.

For auditing purposes, Medicaid may request end of treatment diagnostic models and x-rays. Payment for the end of treatment records will be included in the dollar amount prior authorized. The end of treatment records shall be submitted to the Department for review by the dental consultant.

Documentation Requirements: Submit with the prior authorization requests.

1. A prior authorization request form that outlines treatment to be completed and the Handicapping Labiolingual Deviation (HLD) Index Form in appendix 471-000-406.
2. Diagnostic records, may include – (a) Oral/facial photographic images; (b)Full mouth radiographs (c) Panoramic x-ray; or (d) Cephalometric x-ray;
3. A narrative description of the diagnosis, and prognosis and
4. On surgical cases include a description of the surgical procedure to be completed.

Appendix 471-000-406 contains an orthodontic pre-screen form that shall be used to pre-screen orthodontic cases. This appendix also includes a prior authorization request forms that shall be used to submit pre-treatment prior authorization requests for orthodontic treatment.

For payment of orthodontic treatment see 471 NAC 6-006.

For transfer of orthodontic treatment see 471 NAC 6-006.01.

For orthodontic treatment not completed see 471 NAC 6-006.02.

Services Description	NMAP Coverage/Limitations	Prior Authorization Required
Orthodontic Treatment	To be eligible for orthodontic treatment, a client must be age 20 or younger when treatment is authorized, and meets one of the following handicapping malocclusion categories: 1. Craniofacial birth defect that is affecting the occlusion. 2. Mutilated and severe occlusions. NMAP does not cover orthodontic treatment for malocclusions that are not defined above. When the individual has had a surgical correction (cleft lip or palate, or orthognathic correction), the monthly adjustment procedure is reimbursed at a higher fee. The pre-treatment request must contain documentation of the client's medical condition, or surgical correction. Treatment is prior authorized and paid on a single procedure code. The authorized code will be on the MC-9D prior authorization form or the ASC X 12N 278..	Yes Documentation Requirements: Listed above.
Removable and Fixed Appliance Therapy (thumb sucking and tongue thrust)	Covered for clients age 20 and younger.	No

Services Description	NMAP Coverage/Limitations	Prior Authorization Required
Repair of Orthodontic Appliances	Covered for clients age 20 and younger. Documentation Requirements: Include a description of the repair on or in the dental claim, and in the dental chart.	No
Orthodontic Retainers (Replacement)	Covered for clients age 20 and younger if the client is compliant with wearing the appliance.	No
Repair of Bracket and Standard Fixed Orthodontic Appliances	Covered for clients age 20 and younger. Covered when repairs exceed routine repairs associated with orthodontic treatment. The "unspecified orthodontic procedure, by report" procedure code is billed for this service.	No
ADJUNCTIVE GENERAL SERVICES		
Palliative Treatment	Palliative treatment is covered. Examples of palliative treatment are treatment of soft tissue infection; smoothing a fractured tooth. Documentation Requirements: Document the palliative treatment provided on or in the dental claim, and in the dental chart.	No
General Anesthesia	In office general anesthesia is covered when it is medically necessary to treat the client. Documentation Requirements: Document in the dental chart the medical need for the anesthesia.	No
Analgesia, Anxiolysis, Inhalation of Nitrous Oxide	Covered when medically necessary to treat the client.	No
Intravenous Sedation/Analgesia	In office intravenous sedation/analgesia is covered when it is medically necessary to treat the client. Documentation Requirements: Document in the dental chart the medical need for the anesthesia.	No
Non-Intravenous Conscious Sedation	In office non-intravenous conscious sedation is covered when it is medically necessary to treat the client. Documentation Requirements: Document in the dental chart the medical need for the anesthesia.	No
House Call, (Nursing Facility Call), Hospital Call, Ambulatory Surgical Center (ASC) Call	Covered one per day per facility regardless of the number of patient seen. Documentation Requirements: Document on or in the dental claim the name of the facility, or home address where treatment was provided.	No

Services Description	NMAP Coverage/Limitations	Prior Authorization Required
Office Visit – After Regularly Scheduled Hours	Covered in addition to an exam and treatment provided when treatment is provided after dental office, normal office hours.	No
Occlusal Guard (By Report)	Covered to minimize the effects of bruxism and other occlusal factors. Occlusal guards are defined as removable appliances. Documentation Requirements: Document the medical need for the occlusal guard in the dental chart.	No

6-006 Payment for Interceptive and Comprehensive Orthodontic Treatment: Payment for authorized orthodontic treatment is made upon approval of the treatment plan and submittal of a dental claim.

The procedure code to be used when submitting for payment for orthodontic treatment is the "five"-digit procedure code that was prior authorized by the Department.

Orthodontists shall bill for orthodontic services after receiving an approved prior authorization and after placement of the initial appliances for the orthodontic procedure. Orthodontists shall always re-check Medicaid client eligibility before starting a service, even with an approved prior authorization. Since Medicaid eligibility may vary from month to month, Nebraska Medicaid cannot guarantee that the eligibility for a prior authorized patient will remain constant. If a client becomes ineligible for Medicaid benefits, the authorization becomes void.

The "Fee" on the dental claim must be the dollar amount authorized on the prior authorization.

6-006.01 Transfer of Interceptive and Comprehensive Orthodontic Cases: If the client transfers to another dentist, the authorized dentist shall refund the portion of the amount paid by Medicaid that applies to the treatment not completed to Medicaid.

6-006.02 Interceptive and Comprehensive Orthodontic Treatment Not Completed: If prior authorized orthodontic treatment is not completed, the providing dentist shall refund the portion of the amount paid by Medicaid that applies to the treatment not completed to the Department.

6-007 Standards for Participation: Providers of dental services must be licensed by the Nebraska Department of Health and Human Services as a dentist or a dental hygienist and must practice within their scope of practice as defined in Neb. Rev. Stat. Sections 71-183 to 71-193.20 and 71-193.21 to 71-193.35, and effective December 1, 2008, Neb. Rev. Stat. Sections 38-1101 to 38-1151.

If services are provided outside Nebraska, the dentist or dental hygienist must be licensed in that state and must practice within his/her scope of practice as defined by those state licensing laws.

6-008 Provider Agreement: Providers of dental services shall complete and sign Form MC-19, "Medical Assistance Provider Agreement," (see 471-000-90) and submit the completed form to the Nebraska Department of Health and Human Services for approval to participate in Medicaid.

6-009 Services Provided to Clients Enrolled in the Nebraska Medicaid Managed Care Program Nebraska Health Connection (NHC): Certain NMAP clients are required to participate in the Nebraska Medicaid Managed Care Program known as Nebraska Health Connection (NHC). See 471-000-122 for a listing of the NHC plans. NHC plans may be a Primary Care Case Management (PCCM) plan or a Health Maintenance Organization (HMO) Plan.

The following criteria applies when providing treatment to clients enrolled in NHC:

1. Dental services outlined in this chapter billed on a dental claim are not included in the managed care plan basic benefit package. The dental office must bill these services to Medicaid.
2. Medical and surgical services that are not outlined in this chapter and are billed on Form CMS-1500 or electronically using the standard Health Care Claim: Professional transaction (ASC X12N 837) require the following:
   A. If the client is enrolled in a PCCM plan, the client must have a referral from his/her Primary Care Physician (PCP) to receive these services. Form CMS-1500 or electronic standard Health Care Claim: Professional transaction (ASC X12N 837) is sent to this Department for payment.
   B. If the client is enrolled in an HMO plan, the HMO plan is responsible for the services. The provider must be enrolled with the HMO plan to receive payment. The Form CMS-1500 or electronic standard Health Care Claim: Professional transaction (ASC X12N 837) is sent to the HMO plan for payment.
3. Hospitalization or treatment in an Ambulatory Surgical Center (ASC) requires the following:
   A. If the client is enrolled in a PCCM plan, the client must have a referral from his/her PCP for the admission. The facility claim is sent to this Department for payment.
   B. If the client is enrolled in an HMO plan, the HMO plan must approve the facility admission. The facility charges are billed to the HMO plan. If the treating dentist is not on staff at an HMO enrolled facility, the treating dentist must refer the client to another dentist for treatment.

6-010 HEALTH CHECK (EPSDT) Treatment Services: Services not covered under the Nebraska Medical Assistance Program (NMAP) but defined in Section 1905(a) of the Social Security Act must meet the conditions of items 1 through 8 listed in the definition of "Treatment Services" in 471 NAC 33-001.04. These services must be prior authorized by the Division of Medicaid and Long Term Care.

6-011 Hospitalization or Treatment in an Ambulatory Surgical Center: Dental services must be provided at the least expensive appropriate place of service. For clients enrolled in Nebraska Health Connection (NHC) Medicaid Managed Care, PCCM or HMO medical plan, see 471 NAC 6-009.

6-012 Medical and Surgical Services of a Dentist or Oral Surgeons: Dentists or oral surgeons providing medically necessary services not covered in this chapter must bill the service on Form CMS-1500, "Health Insurance Claim Form" (see 471-000-62) or electronically using the standard Health Care Claim: Professional transaction (ASC X12N 837) using HCPCS/CPT procedure codes. These services are billed through the Physician Program. For clients enrolled in NHC Medicaid Managed Care, PCCM or HMO Plan see 471 NAC 6-009.

6-013 Billing Requirements: The dental claim(s) accepted by Medicaid, and claim(s) completion instructions, are in 471-000-88. Procedure codes accepted by Medicaid are in the Nebraska Medicaid Dental Fee Schedule in 471-000-506.

The fees listed on the dental claim must be the dentist's usual and customary charge for each procedure code.

6-014 Payment for Dental Services: The Nebraska Medical Assistance Program (NMAP) pays for covered dental services at the lower of -

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as -
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

6-015 Revision of the Fee Schedule: The Department may adjust the fee schedule to -

1. Comply with changes in state or federal requirements;
2. Comply with changes in national standard code sets, such as HCPCS, CPT and CDT;
3. Establish an initial allowable amount for a new procedure or a procedure that was previously identified as "RNE" or "BR" based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Division of Medicaid and Long Term Care determines that the current allowable amount is -
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

Providers will be notified of changes and their effective dates.

6-016 Supplemental Payments: Effective July 1, 2010, NMAP will provide a supplemental payment for covered dental services when services are provided or supervised by a faculty or staff member of the University of Nebraska Medical Center (UNMC) College of Dentistry and who is providing or supervising the treatment as part of an approved program of the University.

For dentists qualifying under this section, a supplemental payment will be made. These payments are made in addition to payments otherwise provided under the state plan to dentists that qualify for such payments. The payment amount will be the difference between payments otherwise made to these practitioners and the average rate paid for the services by commercial insurers. The payment amounts are determined by:

1. Calculating annually an average commercial payment per procedure code for all services paid to the eligible providers by commercial insurers using the provider's contracted rates with the commercial insurers for each procedure code. The rate used will be the rate in effect in January for payments during the calendar year.
2. Multiplying the total number of Medicaid claims paid per procedure by the average commercial payment rate for each procedure to establish the estimated commercial payments made for these services. Supplemental and fee schedule/base payment may not in the aggregate exceed this reimbursement ceiling; and
3. Subtracting the initial fee-for-service Medicaid payments and all Third Party Liability payments already made for these services to establish the supplemental payment amount.

The supplemental payments will be calculated 30 days after the end of each FY quarter. The amount due is paid to the UNMC College of Dentistry. No payments are made with the expectation or requirement that some or all of the payment be transferred to another party. A final reconciliation of payments is made one year after the end of each quarter.

Initial fee-for-service payments made under this section will be paid on a claims-specific basis through the Department's claims processing system using the methodology outlined elsewhere in this state plan. The supplemental payment, which represents the final payment, will be made in four quarterly payments.

For each fiscal quarter, the University of Nebraska Medical Center College of Dentistry will provide a listing of the identification numbers for their dentists that are affected by the payment adjustment to the Division of Medicaid and Long-Term Care. The Division will generate a report which includes the identification numbers and utilization data for the affected dentists. This report will be provided to University of Nebraska Medical Center College of Dentistry.

The University of Nebraska Medical Center College of Dentistry must review and acknowledge the completeness and accuracy of the report. After receipt of confirmation, the Division will approve the supplemental payment amount.

Assurances. The Department hereby assures that payment for dental services are consistent with efficiency, economy, and quality of care and payments for services do not exceed the prevailing charges in the locality for comparable services under comparable circumstances.